MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00295

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Stewart Nursing Home, Greensboro Md
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ruithanna Bell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S**********

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1944

8. AGE: Years | Months: 3 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Greensboro, Caroline, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Andrew Bell
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna Griffith
15. Birthplace: Del.

16. Informant: Andrew Bell
Address: Greensboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 21 45 (month) (day) (year)
Cemetery or crematory: Greensboro
Location: Greensboro, Md.

18. Funeral director: Raymond B. Rawlings
Address: Greensboro, Md.

19. Jan 19 1945 (Date rec'd by registrar) L. MacPippin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1945, to January 17 1945 and that I last saw her alive on January 17 1945

Immediate cause of death	DURATION
Broncho pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H Straes M.D.
M. D. or other
Address: Greensboro, Md. Date signed 1-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00296

CERTIFICATE OF DEATH

Reg. Dist. No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Caroline.
City or town: Greensboro.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lida J. Cooper.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed.

6.(b) Name of husband or wife: George Cooper.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 18. 1858

8. AGE: Years	Months	Days	If less than one day
86	10	13	hrs. min.

9. Birthplace: Felton Kent Co Del.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business:

FATHER
12. Name: Joseph Linnell.
13. Birthplace: Del.

MOTHER
14. Maiden name: Caroline Sims
15. Birthplace: Del.

16. Informant: Alma M. Rawlings.
Address: Greensboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4. 1945 (month) (day) (year)
Cemetery or crematory: Greensboro Md.
Location: Greensboro Md.

18. Funeral director: Raymond B. Rawlings
Address: Greensboro.

19. Jan. 31 1945 (Date rec'd by registrar) L. MacPippin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 19 45 at 7.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to Jan 31 19 45 and that I last saw h.. alive on Jan 31 19 45

Immediate cause of death	DURATION
Myocarditis	
Due to: Arteriosclerosis	
Due to: Cerebral Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas H. Stevens M.D.
M. D. or other
Address: Greensboro Md. Date signed Jan 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

00297

Reg. Diat. No. 67

1. PLACE OF DEATH:
County: Caroline
City or town: Denton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Denton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: Mrs Maurie Haynes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	married

6.(b) Name of husband or wife: Sherman Haynes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 8th 1896

8. AGE:	Years	Months	Days	If less than one day
	48	8	7	..... hrs. ..... min.

9. Birthplace: Denton Caroline County, (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Joseph Jadson
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Henrietta Hall
MOTHER 15. Birthplace: Denton Md
16. Informant: Haynes, Hensley
Address: Chester Rd
17. Buried (Burial, cremation, or removal. Which?) Date thereof 1 — 18 — 46 (month) (day) (year)
Cemetery or cremstory: Spring Grove Cemetery
Location: Denton Md.
18. Funeral director: J. Virgil Thomas
Address: Denton Md.
19. 1-18 1946 (Date rec'd by registrar) Mrs D Jester Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1946 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to Coronary Occlusion	Sudden
Due to Chronic Endocarditis	7
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Aaron D George Coroner M. D. or other
Address: Denton Md Date signed 1/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

00298

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro Rural
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Greensboro Rural.
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julia Hemrich

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Maried.

6.(b) Name of husband or wife: Jaime Hemrich
6.(c) If alive, give age: 5-6 years
7. Birth date of deceased (mo., day, yr.): Dec. 12. 1896

8. AGE: Years	Months	Days	If less than one day
49	1	9	hrs. min.

9. Birthplace: Austria Hungary.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Steve Hrula.
13. Birthplace: Austria Hungary.
MOTHER 14. Maiden name: Viakuom
15. Birthplace: Austra Hungaray.
16. Informant: Jaime Hemrich
Address: Greensboro Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23. 1945 (month) (day) (year)
Cemetery or crematory: Greensboro.
Location: Greensboro Md.
18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.
19. Jan. 23 1945 (Date rec'd by registrar) L Mat Leggin (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1945; at 9.15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 2 1943, to Jan. 20 1945
and that I last saw h...er alive on January 19 1945

Immediate cause of death	DURATION
Carcinoma of Breast	2 yrs.
with Metastases to Lungs	
& Bone.	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)
Major findings of operations: Radical Breast.
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H Howes M.D.
M. D. or other
Address: Greensboro Md. Date signed: Jan 22 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

00299

Reg. Diat. No. 62

1. PLACE OF DEATH:

County: Caroline

City or town: Denton (Incl)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Artemus Jester

3.(b) Social Security Number: 218-05-8277

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband ~~or wife~~: Mrs. Florence Jester

6.(c) If alive, give age: 60. ~~years~~

7. Birth date of deceased (mo., day, yr.): May 25th 1884

8. AGE: Years	Months	Days	If less than one day
66	8	11	....hrs. ....min.

9. Birthplace: Harmony, Maryland (Town, county, and state)

10. Usual occupation: Day Labor.

11. Industry or business

FATHER — 12. Name: William Jester

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sallie Blondi

15. Birthplace: Md.

16. Informant: Mrs. F. Jester Wife

Address: Fountain ave. Denton Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1—14—45 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton Md.

18. Funeral director: J. Virgil Freeman Sons

Address: Denton Md.

19. Jan 14th 1945 (Date rec'd by registrar) Mrs D. O George Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1945 at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 1943 to Jan 11 1945 and that I last saw him alive on Dec 23 1944

Immediate cause of death	DURATION
Coronary artesis sclerosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Paul Griffith MD M. D. or other

Address: Denton Md Date signed 1/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

00300

State File No. _____
Registrar's No. 242

State of Maryland

1. PLACE OF DEATH:
(a) County Carolina
(b) City or town Federalsburg (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: — — (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — — (Specify whether years, months or days)
In this community — —

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County _____
(c) City or town Albany (If outside city or town limits, write RURAL)
(d) Street No. 258 Lenox Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A.? — — years.

3. (a) FULL NAME STUART DAVID KESTENBAUM
3. (b) If veteran, name war — —
3. (c) Social Security No. — —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — — years
7. Birth date of deceased May (Month) 9 (Day) 1922 (Year)

8. AGE: Years 22 | Months 8 | Days 9 | If less than one day — hr. — — min.

9. Birthplace Hudson, New York (City, town, or county) (State or foreign country)
10. Usual occupation Pilot
11. Industry or business U. S. Army
MOTHER FATHER
12. Name Herbert H. Kestenbaum
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Official Records
(b) Address Camp Springs AAFld., Wash., D.C.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1945 (Month) (Day) (Year)
(c) Place; burial or cremation Hudson, New York
18. (a) Signature of funeral director Chas. Szumbert
(b) Address 301 E. Capitol St., Wash., D.C.
19. (a) 1-25345 (Date received local registrar) (b) Sydney Broadmeadow (Registrar's signature)

MEDICAL CERTIFICATION
20. Date of death: Month January day 18th
year 1945 hour 5 minute 40 P.M.
21. I hereby certify that I attended the deceased from _____, 19___, to _____, 19___:
that I last saw h___ alive on _____, 19___:
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Violent Trauma	
Due to: Airplane Crash	
Due to: — —	
Other conditions — — (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations — —
Of autopsy — —

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence January 18, 1945
(c) Where did injury occur? Federalsburg, Carolina, Md (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? Yes (e) Means of injury Airplane
23. Signature Lambert E. Ayres Capt. (M. D. or other)
Address Camp Springs AAFld, Wash, DC Date signed 1/25/45

8-6017 U. S. GOVERNMENT PRINTING OFFICE 16—13403

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00301

Reg. Diat. No. 62

1. PLACE OF DEATH:

County: Caroline

City or town: Denton (If outside city or town limits, write RURAL and give nearest town) Md.

How long in above place of death? 77 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lennie Bennett Percy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	widow

6.(b) Name of husband or wife: Richard Percy Dec'd.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1867

8. AGE: Years: 77 | Months: 6 | Days: | If less than one day: hrs. min.

9. Birthplace: Denton (Town, county, and state) Md.

10. Usual occupation: at home

11. Industry or business:

FATHER 12. Name: Josiah Bryant

13. Birthplace: Harford Co. Md.

MOTHER 14. Maiden name: Sarah A. Cook

15. Birthplace: Queen Anne Co. Md.

16. Informant: Mrs. Bryant Booker

Address: Denton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-8-45 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton Caroline Co.

18. Funeral director: J. Virgil Maddox & Son

Address: Denton Md.

19. Jan. 8 1945 (Date rec'd by registrar) M. R. Greene Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to Jan 6 1945 and that I last saw her alive on Jan 5 1945

Immediate cause of death	DURATION
Due to Chronic Myocarditis	10 yrs.
Due to Carcinoma of Stomach	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dawson S. Teague M. D. or other

Address: Denton Date signed: 1/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of birth date & age of deceased is shown on FILM No. G 93 MAR 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

Evidence for change of cause of death is shown on FILM No. G 94 APR 7 1945

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Caroline
City or town: Hillsboro Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: 00302
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Greensboro Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Porter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Marr

6.(b) Name of husband or wife: Mary Melvina Porter
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Nov. 19- 1907- 1904

8. AGE:	Years	Months	Days	If less than one day
40	38	1	25	hrs. min.

9. Birthplace: Hillsboro Caroline Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ✓

FATHER
12. Name: Priestley Porter.
13. Birthplace: Md

MOTHER
14. Maiden name: Mary S Cane
15. Birthplace: Md

16. Informant: Mrs. Mary K Porter.
Address: Hillsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17, 45 (month) (day) (year)
Cemetery or crematory: Greensboro
Location: Greensboro Md.

18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.

19. Jan. 17 1945 (Date rec'd by registrar) L. Mac Pippin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1945 at 6 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to: Burned to death	Instant
Trapped in burning building	
Due to: his home.	
Due to: Fire	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dawson D George Coroner
M. D. or other
Address: Denton Md Date signed: 1/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

00303

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:

County: Caroline.

City or town: Greensboro Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State: Md County: Caroline

City or town: Greensboro Md Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, gives LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Shirley T. Porter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10. 1939

8. AGE: Years 5 | Months 10 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Greensboro Caroline Md. (Town, county, and state)

10. Usual occupation School Girl.

11. Industry or business ✓

FATHER 12. Name George Porter

13. Birthplace Md

MOTHER 14. Maiden name Mary Melvin

15. Birthplace Md.

16. Informant Mary Porter

Address Greensboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17. 45 (month) (day) (year)

Cemetery or crematory Greensboro.

Location Greensboro. Md.

18. Funeral director Raymond B. Rawlings

Address Greensboro Md.

19. Jan. 17 1945 (Date rec'd by registrar) L. MacPherson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945 at 6 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Due to Burned to death:	immediate
Trapped in a burning building. Fire	
Due to home.	
C.V.D.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dawson D George M. D. or other

Address Denton Md Date signed 1/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

00304

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:

County: Caroline.

City or town: Greensboro Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Caroline

City or town: Greensboro, Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Earl Porter.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... yeurs

7. Birth date of deceased (mo., day, yr.) July 29. 1929.

8. AGE: Years	Months	Days	If less than one day
15	5	16	..... hrs. ..... min.

9. Birthplace: Greensboro Caroline Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: George Porter.

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Melvin

15. Birthplace: Md.

16. Informant: Mary Porter

Address: Greensboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17. 45 (month) (day) (year)

Cemetery or crematory: Greensboro

Location: Greensboro Md.

18. Funeral director: Raymond B. Rawlings

Address: Greensboro Md.

19. Jan. 17 1945 (Date rec'd by registrar) L. MacPherson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1945 at 6 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death:	
Due to: Burned to death:	Unknown
Due to: Trapped in a burning building.	
his home.	
Other conditions: Cause	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lawson T. George coroner M. D. or other

Address: Denton Md Date signed 1/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

00305

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Greensboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 months

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Denton - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Concord

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Laura B. Sullivan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 6, 1863

8. AGE: Years	Months	Days	If less than one day
81	9	7	... hrs. ... min.

9. Birthplace Caroline County, Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Thomas A. Sullivan

13. Birthplace Caroline County, Maryland

MOTHER 14. Maiden name Sarah Ann Beauchamp

15. Birthplace Caroline County, Maryland

16. Informant Mrs. Daisy Tribbitt

Address Greensboro, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 15 1945 (month) (day) (year)

Cemetery or crematory Concord Cemetery

Location Denton Maryland R.F.D.

18. Funeral director J. J. Frampton and Son

Address Frederalsburg, Maryland

19. January 15 1945 (Date rec'd by registrar) J. J. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1945, at 5:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1944, to Jan. 13 1945 and that I last saw h... alive on Jan. 12 1945

Immediate cause of death	DURATION
Cardiac Renal Disease	
Due to Arteriosclerosis	
Due to Arterio Sclerotic Cardiac Renal Vascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatinns ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the canse tn which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Chas. M. Hammond M.D.

M.D. or other

Address Greensboro Md Date signed 1-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00306

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

Reg. Diat. No. 62

1. PLACE OF DEATH:

County: Caroline

City or town: Denton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Denton
(If ontside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Hawley Tribbitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife: Sherman Tribbitt

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.): July 6th 1895

8. AGE: Years 49 | Months 7 | Days 24 | If less than one day ... hrs. ... min.

8. Birthplace: Denton Caroline County
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Willard Hawley

13. Birthplace: Del.

MOTHER 14. Maiden name: Jewell

15. Birthplace: Del.

16. Informant: Sherman Tribbitt

Address: Denton Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1-23-45 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton Md.

18. Funeral director: J. Tilgh Emerson & Son

Address: Denton Md.

19. 1-23 1945 (Date rec'd by registrar) Mrs A O George Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20th 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1945 to Jan. 20 1945 and that I last saw h.. alive on Jan. 20 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dawson D. George M. D. or other

Address: Denton Date signed 1/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

00307

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Federalsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
Park Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Park Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME Oscar W. Turner

3. (b) Social Security Number 220-07-0341

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Sarah Smith Turner

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 14, 1897

8. AGE:	Years	Months	Days	If less than one day
	47	0	20	...hrs. ...min.

9. Birthplace Federalsburg, Maryland
(Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business Federalsburg Package Company

FATHER
12. Name John Edward Turner
13. Birthplace Caroline County, Maryland

MOTHER
14. Maiden name Annie E. Neal
15. Birthplace Caroline County, Maryland

16. Informant Mrs. Ethel Magee

Address Federalsburg, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 8 1945 (month) (day) (year)

Cemetery or crematory Federal Hill Cemetery

Location Federalsburg, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. January 5 1945 (Date rec'd by registrar) J. J. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1945, at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

	DURATION
Immediate cause of death	
Due to Cardiac Exhaustion	Duration
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alexander D. George M. D. or other

Address Denton Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15